

LYME DISEASE CASE REPORT - Page 1 of 2

Indiana State Department of Health
State Form 51933 (10-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: ☐ Not like this: ☒ Mark mistakes like this: ☒
- 4 Print capital letters only and numbers completely inside boxes.

A	2	C	3
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- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

Section 1. Demographic Information

<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>		
Last Name		
<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>
First Name	MI	Phone Number
<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>		
Number & Street Address		
<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>
City	State	ZIP Code
<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>
County	Date of Birth	Age
<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>
Race:	Ethnicity:	Is Age in day/mo/yr?
<input type="radio"/> Asian	<input type="radio"/> White	<input type="radio"/> Hispanic or Latino
<input type="radio"/> Black or African American	<input type="radio"/> Other/Multiracial	<input type="radio"/> Not Hispanic or Latino
<input type="radio"/> American Indian or Alaska Native	<input type="radio"/> Unknown	<input type="radio"/> Unknown
<input type="radio"/> Native Hawaiian or Other Pacific Islander	Sex:	<input type="radio"/> Days
	<input type="radio"/> Male	<input type="radio"/> Months
	<input type="radio"/> Female	<input type="radio"/> Years
	<input type="radio"/> Unknown	

Section 2. Clinical Information

Symptoms and Signs of Current Episode (Please mark each question):

DERMATOLOGIC:

Erythema migrans (physician diagnosed EM at least 5 cm in diameter)? ☐ Yes ☐ No ☐ Unknown

RHEUMATOLOGIC:

Arthritis characterized by brief attacks of swelling in one or a few joints? ☐ Yes ☐ No ☐ Unknown

NEUROLOGIC:

Bell's palsy or other cranial neuritis? ☐ Yes ☐ No ☐ Unknown

Radiculoneuropathy? ☐ Yes ☐ No ☐ Unknown

Lymphocytic meningitis? ☐ Yes ☐ No ☐ Unknown

Encephalitis/Encephalomyelitis? ☐ Yes ☐ No ☐ Unknown

Antibody to B. burgdorferi higher in CSF than serum? ☐ Yes ☐ No ☐ Unknown or Not Tested

CARDIOLOGIC:

2nd or 3rd degree atrioventricular block? ☐ Yes ☐ No ☐ Unknown

Other Clinical

<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>	<div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div>
Date of Onset	Date of Diagnosis	Date of Report to Health Department

Other History:

Was the patient hospitalized for the current episode? ☐ Yes ☐ No ☐ Unknown

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Name of antibiotic(s) used this episode	Use in days

Was the patient pregnant at the time of illness? ☐ Yes ☐ No ☐ Unknown

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Section 2. Clinical Information (continued)

If EM was diagnosed, did the patient travel out of county of residence during the month prior to EM onset?

☐ Yes ☐ No ☐ Unknown

If Yes, County State

Where was the patient most likely exposed?

County State

Section 3. Laboratory Results

Lyme Antibody:	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Equivocal	<input type="radio"/> Not done/Unknown
Western Blot IgM:	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Equivocal	<input type="radio"/> Not done/Unknown
Western Blot IgG:	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Equivocal	<input type="radio"/> Not done/Unknown
Other:	<input type="radio"/> Positive	<input type="radio"/> Negative	<input type="radio"/> Equivocal	<input type="radio"/> Not done/Unknown

If Other, specify

Physician's Name

Physician's Address

City State ZIP Code

Physician's Phone

Section 4. Comments/Follow-up

Comments:

Person Completing Form (if not physician)

Address

Phone Number Date